l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	E SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
1551:		155128	B. WIN			09/15/2	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	L		1				
OVE	DIVISION OF WHIT	TLEY MEMORIAL HOSPITAL			VOLF RD IBIA CITY, IN46725			
OANS-A	DIVISION OF WHITE	TEET MEMORIAL HOSFITAL		COLUN	IBIA CITT, IN40725			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000								
	This visit was for	r the Investigation of	F0000					
	Complaint IN000	096605.						
	F							
	Commissint INIOO	006605 Substantiated						
	•	096605-Substantiated,						
		ficiency related to the						
	allegations is cite	ed at F-441.						
	Survey Dates: S	eptember 14 & 15, 2011						
		.,						
	Facility number: 000055 Provider number: 155128 AIM number: 100288410 Survey team: Angela Strass, RN TC							
	_							
	Rick Blain, KN ((September 14, 2011)						
	Census bed type:							
	SNF/NF: 49							
	SNF: 8							
	Total: 57							
	1011. 57							
	Census payor typ	be:						
	Medicare: 11							
	Medicaid: 26							
	Private: 20							
	Total: 57							
	20001.							
	Sample: 3							
	This deficiency a	also reflects state findings						
	cited in accordan	nce with 410 IAC 16.2.						
					<u> </u>			
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W4E011 Facility ID: 000055 If continuation sheet Page 1 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155128	A. BUILDING B. WING	00 	COMP 09/15/	LETED		
NAME OF PROVIDER OR SUPPLIER OAKS-A DIVISION OF WHITLEY MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 411 N WOLF RD COLUMBIA CITY, IN46725					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	Quality review c 16, 2011 by Bev	ompleted on September Faulkner, RN						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) MUL) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		155128		A. BUILDING B. WING			COMPLETED	
							09/15/2011	
			B. WING		DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					OLF RD			
OAKS-A	DIVISION OF WHIT	LEY MEMORIAL HOSPITAL			BIA CITY, IN46725			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0441 SS=D	Infection Control F a safe, sanitary an and to help prever	establish and maintain an Program designed to provide and comfortable environment at the development and sease and infection.						
	Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should bresident; and (3) Maintains a reconstruction.	stablish an Infection Control nich it - ontrols, and prevents						
	determines that a prevent the spread must isolate the re (2) The facility must communicable dis lesions from direct their food, if direct disease. (3) The facility must hands after each control of the spread of	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted						
	transport linens so infection. Based on observa interview, the fact followed infection related to hand h	andle, store, process and o as to prevent the spread of ations, record review and cility failed to ensure staff on control practices ygiene and disposal of we equipment for 1 of 3	F04	141	F441 Infiecton Control Listted below are our response tto F441 cittatton This serves as our credible allegatton oft compliance additton, we respectfully request	In	09/30/2011	

000055

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155128		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL			
			A. BUI	LDING	00	09/15/20		
		B. WIN			09/15/20	711		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
OALKO A DIVIGIONI OF MULTI-EVANEMODIAL LICODITAL				1	VOLF RD			
UAKS-A	OAKS-A DIVISION OF WHITLEY MEMORIAL HOSPITAL			COLUMBIA CITY, IN46725				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG			DATE	
	`	ent A) during 2 of 2			be considered ftor paper compliar	I		
		his involved Nurse #2 and			Itt is tthe practtce oft tthis ftacilitty provide a safte sanittary and	γπο		
	CNA #1.				comftorttable environmentt tto pr	eventt		
					tthe developmentt and ttransmiss			
	Finding includes	3:			oft disease and inftectton			
					1			
	During observat	ion of Resident (A) on			What correctve actons will be			
	9/14/11 at 10:30	a.m., a sign was noted on			accomplished fior the resident			
	the resident's do	or directing visitors to see			fiound to have been afiected by t	he		
	nurse. In interview with Nurse #1 at this time, the nurse indicated resident (A) was on contact isolation precautions.				deficient practce ?			
					 Residentt(A) remains in stt conditton. The wound has been 	able		
					culttured and tthe physician has			
	Review of the clinical record on 9/14/11 at 1:30 p.m., indicated Resident (A) had a MRSA (methicillin resistant				dettermined tthe residentt is now	ftree		
					oft inftectton			
					· Inftectton conttrol procedu	ures		
					have been ftollowed by all sttaft tt	hatt		
	staphylococcus aureus) infection of a				have tthe pottenttal tto come intto			
					conttactt witth Residen(At). Residen	ntt		
	surgical wound. Review of the record				(A) is no longer in isolatton.			
	indicated the wound was being treated daily and had a dressing covering the				· All sttaft have been			
					re-educatted in hand washing procedures, glove use, and conttact	ctt		
	wound.				isolatton procedures. See attached			
					attendance sheett			
		he resident on 9/14/11 at			II			
	2:55 p.m., noted the resident was in her bed. Nurse #2 came into the room wearing a disposable gown and a pair of gloves. Nurse #2 proceeded to check the resident's intravenous line and antibiotic bag which was hanging on the intravenous pole. The nurse then left the room without removing her gloves or gown. Nurse #2 was queried outside of the door				How will the fiacility identify other	er		
					residents having the potental to b	oe		
					afiected by the same deficient			
					practce and what correctve acton	1		
					will be taken? All residentts are att risk of	_{ft}		
					inftectton when making conttactt	1		
					a communicable disease.			
					· All residentts witth active			
					communicable inftecttons will be			
	1	room, and was observed			placed in a level oft isolatton			
					precautton indicatted by tthe ttype and			
	to be holding her gown and gloves in her							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155128 09/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 N WOLF RD OAKS-A DIVISION OF WHITLEY MEMORIAL HOSPITAL COLUMBIA CITY, IN46725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE hand. The nurse was asked where she locatton oft inftectton per ftacilitty was going to dispose of the gown and The ttype and locatton oft gloves and she indicated, while coming inftectton will be dettermined by back into the room, that she needed a red cultture and sensittvitty ttestts done by bag but there were none in the room. The an accreditted laborattory and nurse proceeded to place the gown and identtfted by a licensed physician gloves in the trash can in the bathroom Facilitty sttaft have been and left the room. The nurse returned to re-educatted on washing or sanittzing hands beftore and after residentt the room with a red bag and hung it on the conttacttglove use and indicattons edge of a bedside table. She secured the ftor changing gloves and proper bag to the table by placing a puzzle box disposal oft isolatton personal and a canister on the edge of the bag. prottecttve equipment(PPE). Nurse #2 reached into the trash can in the Ш What measures will be put into bathroom and removed her gown and place or what systemic changes will gloves from the trash with her bare hands be made to ensure that the and then placed the gown and gloves in deficient practce does not recur? the red bag in the resident's room. The The ftacilitty is implementing a hand nurse started to leave the room, opened washing inittattve tthatt place's Hand the door and turned around and applied Hygiene Champions" on every shift. These individuals are specially hand sanitizer to her hands from a ttrained in hygienic procedures and container on the wall by the bathroom. will be observing otther sttaft and providing spott ttraining ift tthey Observation of the resident on 9/15/11 at recognize a problem. See attached 9:00 a.m..noted the resident was in the educatton packett bathroom seated on the toilet. CNA #1 All sttaft were rettrained in hand hygiene and conttactt isolatton was in the bathroom with the resident and procedures tthe week oft Septtember had on a gown and gloves. The resident 26, 2011 tthrough Septtembe 80, was assisted to a standing position, and 2011. See attached ttraining provided perineal care. Without removing conftrmatton sheetts her contaminated gloves, the CNA How will the correctve acton (s) be assisted the resident to her chair in the monitored to ensure the deficient room. The CNA touched the resident's practce will not recur, i.e., what walker, picked up a blanket from the bed quality assurance program will be and placed it on the resident's legs. The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIII	LDING	00	COMPLETED	
155128		B. WIN			09/15/2011	
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					VOLF RD	
OAKS-A DIVISION OF WHITLEY MEMORIAL HOSPITAL					IBIA CITY, IN46725	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE
	CNA was then ol	oserved to remove her			put into place?	
	gloves and wash	her hands.			· Sttaft will be observed by tthe	
					DON/Designee during routtne	
	On 9/15/11 at 11	:30 a.m., review of the			inftectton conttrol QA audittResul	tts
		ransmission Based			will be submitted tto tthe QA	
	''	ich was not dated,			Committee montthly 2, tthen ever	i yo
	indicated the foll	·			montths on an ongoing basis Inftectton rattes witthin ttl	he
	indicated the foli	owing.			ftacilitty are ttracked and evaluate	
	G1 17				montthly as a sttandard Qualitty	
	Glove Use:				Assurance Committee agenda itte	m I
	a. Always wear well -fitting gloves b. Always work from clean to dirty c. Limit opportunities for "touch contamination" f. Hand hygiene should precede donning of gloves, and follow removal of gloves in				Resultts are submitted tto tthe Qu	
					Assurance Committee ftor review	and
					ftollow up on an ongoing basis Fo	r
					issues identtfted, an Actton Plan w	vill
					be developed.	
	every mstance					
	Hand Hygiene:					
	a. Always perfo	orm hand hygiene using				
	either alcohol bas	sed hand sanitizer or soap				
	and water:					
	i. Before tou	ching the patient				
		• .				
	1					
	1 *	v fluid exposure				
	 iii: After body fluid exposure iv: After touching the patient v: After touching the patient surroundings b. Hand hygiene must be performed 					
	before donning p	ersonal protective				
	equipment					
		must be performed after				
	f. Hand hygien of gloves, and fo every instance Hand Hygiene: a. Always perfeeither alcohol base and water: i. Before tou ii. Before perocedures iii: After bod iv: After touch v: After touch surroundings b. Hand hygiene before donning pequipment c. Hand hygiene	orm hand hygiene using sed hand sanitizer or soap ching the patient rforming clean/aseptic y fluid exposure sing the patient thing the patient whing the patient se must be performed			·	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155128		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	ľ í	E SURVEY PLETED 2011			
NAME OF PROVIDER OR SUPPLIER OAKS-A DIVISION OF WHITLEY MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 411 N WOLF RD COLUMBIA CITY, IN46725					
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PREFIX	(EACH DEFICIENT REGULATORY OR COntact Precauti a. Don all persoupon every entra b. Remove all pequipment within time of exit c. Discard all pequipment within equipment equ	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION		